

# Connecticut Department of Public Health

## Hospice Inpatient Facilities

### HOSPICE INPATIENT FACILITIES

#### Section 19a-495-6a Hospice Inpatient Facilities

Definitions. As used in Sections 19a-495-6a through 19a-495-6m, inclusive, of the Regulations of Connecticut State Agencies:

- (1) "Adverse event" means a discrete, auditable and clearly defined occurrence with a negative consequence of care that results in unanticipated injury, illness, or death which may or may not have been preventable;
- (2) "Attending practitioner" means a physician, or an advance practice registered nurse, licensed in Connecticut (who may or may not be an employee of the hospice inpatient facility) identified by the terminally ill patient or family as having a significant role in the determination and delivery of the patient's medical care;
- (3) "Bereavement" means the extended period of grief, which is usually thirteen months, preceding the death and following the death of a loved one, during which individuals experience, respond and adjust emotionally, physically, socially and spiritually to the loss of a loved one;
- (4) "Bereavement counseling" means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment;
- (5) "Clinical experience" means employment in providing patient services in a health care setting;
- (6) "Commissioner" means the Commissioner of Public Health, or the commissioner's designee;
- (7) "Complementary therapies" means non-traditional therapies that are used in combination with standard medical treatments, including, but not limited to, massage, yoga, art or music therapy;
- (8) "Comprehensive assessment" means a thorough evaluation of the patient's physical, psychosocial, emotional and spiritual status and needs related to the terminal illness and related conditions. This includes an evaluation of the caregiver's and family's willingness and capability to care for the patient;
- (9) "Contracted services" means services provided by the hospice inpatient facility which are subject to a written agreement with an individual, another agency or another facility;
- (10) "Contractor" means any organization, individual or facility that is hired or paid to provide services to hospice patients under a written agreement with the hospice inpatient facility;
- (11) "Department" means the Department of Public Health;
- (12) "Dietary counseling" means education and interventions provided to the patient and family regarding appropriate nutritional intake as the patient's condition progresses. Dietary counseling is provided by qualified individuals, which may include an advanced practice registered nurse, registered nurse, registered dietician or nutritionist, when identified in the patient centered plan of care;
- (13) "Direct service staff" means individuals employed or under written agreement with the hospice inpatient facility whose primary responsibility is delivery of care to patients;
- (14) "Family" means an individual or a group of individuals whom the patient identifies as such regardless of blood relation or legal status;

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- (15) "Full-time" means employed and on duty not less than thirty-five hours per work week on a regular basis;
- (16) "Twenty-four hour basis" means services provided twenty-four hours per day, seven days per week;
- (17) "Hospice care" means a comprehensive set of services identified and coordinated by an interdisciplinary team to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and the patient's family members, which shall be delineated in the individualized patient centered plan of care across all care settings;
- (18) "Hospice inpatient facility" means a facility or hospice residence that provides palliative care for hospice patients requiring short-term, general inpatient care for pain and symptom management, end of life care or respite care and provides the services required pursuant to 19a-122b of the Connecticut General Statutes;
- (19) "Initial assessment" means an evaluation of the patient's physical, psychosocial and emotional status at the time of admission related to the terminal illness and related conditions to determine the patient's immediate care and support needs;
- (20) "Inpatient respite care" means short-term inpatient care provided to terminally ill patients to provide relief to family members or others caring for the patient;
- (21) "Interdisciplinary team" means a group of individuals who work together to meet the physical, medical, psychosocial, emotional and spiritual needs of the hospice patients and families facing terminal illness and bereavement. The team shall include: a physician, registered nurse, social worker, spiritual counselor and other persons as may be deemed appropriate;
- (22) "Licensed independent practitioner" means an individual licensed in Connecticut as a physician, or an advanced practice registered nurse;
- (23) "Licensee" means a person, group of persons, association, organization, institution, or agency, public or private that is licensed in accordance with section 19a-495-6b of the Regulations of Connecticut State Agencies;
- (24) "Medical director" means a physician with experience and training in hospice care licensed to practice medicine in Connecticut in accordance with Chapter 370 of the Connecticut General Statutes;
- (25) "Nurse" means a person licensed under chapter 378 of the Connecticut General Statutes to practice nursing as an advanced practice registered nurse, registered nurse, or licensed practical nurse;
- (26) "Nursing assistant" means the hospice aide, home health aide, or a nurse's aide who is registered and in good standing on the nurse's aide registry maintained by the department in accordance with section 20-102bb of the Connecticut General Statutes;
- (27) "Occupational therapy" shall have the same meaning as provided in section 20-74a of the Connecticut General Statutes and shall be performed in accordance with accepted standards of practice and applicable law by an occupational therapist or occupational therapy assistant licensed under Chapter 376a of the Connecticut General Statutes;
- (28) "Palliative care" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and

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- spiritual needs and the facilitation of patient autonomy, access to information, and choice;
- (29) "Patient" means a person that is terminally ill and has a medical prognosis with a life expectancy of 6 months or less if the illness runs its usual course;
- (30) "Patient centered plan of care" means a comprehensive individualized written plan of care established by the interdisciplinary team in collaboration with a licensed independent practitioner, and the patient or family that addresses the physical, intellectual, emotional, social, and spiritual needs of the patient;
- (31) "Pharmacist" shall have the same meaning as provided in section 20-571 of the Connecticut General Statutes;
- (32) "Physical Therapy" shall have the same meaning as provided in section 20-66 of the Connecticut General Statutes and shall be performed by a physical therapist or physical therapist assistant who is licensed under Chapter 376 of the Connecticut General Statutes;
- (33) "Physician" shall have the same meaning as provided in section 20-13a of the Connecticut General Statutes;
- (34) "Physician assistant" shall have the same meaning as provided in section 20-12a of the Connecticut General Statutes;
- (35) "Quality care" means that the patient receives clinically competent care that meets current professional standards, is supported and directed in a planned pattern toward mutually defined outcomes, achieves maximum symptom management and comfort consistent with individual potential life style and goals, receives coordinated service through each level of care and is taught self-management and preventive health measures;
- (36) "Representative" means a designated member of the patient's family or person legally authorized to act for the patient in the exercise of the patient's rights in accordance with applicable law;
- (37) "Restraint" means:
- (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move the arms, legs, body, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, methods that involve the physical holding of a patient for the purpose of escorting the patient or conducting a routine physical examination or test, methods or devices intended to protect the patient from falling out of bed or allowing the patient to participate in an activity without the risk of physical harm; or
  - (B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition;
- (38) "Seclusion" means the involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving;
- (39) "Social work services" means services provided in accordance with accepted standards of practice and applicable law by a licensed clinical social worker or licensed master social worker licensed under Chapter 383b of the Connecticut General Statutes;

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- (40) "Speech and language therapy services" means services provided in accordance with accepted standards of practice and applicable law by a speech and language pathologist licensed under Chapter 399 of the Connecticut General Statutes;
- (41) "Spiritual counseling" means the assessment and delivery of services in accordance with the patient and family's beliefs;
- (42) "Spiritual counselor" means a person who is ordained clergy (individual ordained for religious service), pastoral counselor or other person who can support the patient's spiritual needs;
- (43) "Statement of ownership and operation" means a written statement as to the legal owners of the premises and legal entity that operates the hospice inpatient facility to be licensed; and
- (44) "Volunteer" means a person who receives no remuneration for services provided to the hospice inpatient facility.

#### Section 19a-495-6b Licensure Procedures

- (a) No person, group of persons, association, organization, institution or agency, public or private shall establish, conduct or maintain a hospice inpatient facility without a license issued by the Commissioner of Public Health in accordance with this section except as provided in section 19a-491 of the Connecticut General Statutes. Such person or entity shall secure such license and any other required government authorization to provide hospice care services for terminally ill persons on a twenty-four-hour basis in all settings including, but not limited to, a private home, nursing home, residential care home or specialized residence that provides supportive services and shall present to the department satisfactory evidence that such person or entity has retained the services of qualified personnel necessary to provide services in such settings.
- (b) Application for initial or renewal licensure.
  - (1) Application for the initial granting or renewal of a license shall be made by the applicant to the department, in writing, on forms provided by the department.
  - (2) The application shall be signed by the owner of the hospice inpatient facility or by a person duly authorized to act on behalf of owner of the facility and shall include responses to all the information required on the forms provided by the department. The application shall be signed under oath, the signature notarized and the application form shall cite the provisions of section 53a-157b of the Connecticut General Statutes.
  - (3) Application for the grant or renewal of a license to operate a hospice inpatient facility shall include the following information, if applicable:
    - (A) Statement of ownership and operation;
    - (B) Names and titles of professional and unlicensed direct care employees;
    - (C) Signed acknowledgement of duties for the administrator, medical director, and director of nurses upon initial application only;
    - (D) Patient capacity;
    - (E) Total number of employees, by category;
    - (F) Services provided;
    - (G) Evidence of financial capacity;
    - (H) Certificates of malpractice and public liability insurance; and
    - (I) Local Fire Marshal's biennial license;

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- (J) Affidavits as described in section 19a-491a(a) of the Connecticut General Statutes;
  - (K) Reports from criminal history and patient abuse background searches pursuant to section 19a-491c of the Connecticut General Statutes;
  - (L) The licensing or renewal fee as provided in the Connecticut General Statutes; and
  - (M) Such additional information as the Department may request.
- (4) Any person who makes a material false statement in an application shall be subject to penalties in accordance with section 19a-500 of the Connecticut General Statutes.
- (c) Issuance and renewal of license.
- (1) The commissioner may, in the commissioner's discretion, deny an application for licensure or a renewal application for any of the following reasons:
    - (A) The license application or renewal application is not complete;
    - (B) The applicant's failure to comply with applicable federal, state and local laws;
    - (C) If the commissioner determines that any of the individuals identified in subsection (b)(3) of this section have been subject to any of the criminal, civil or administrative actions described in section 19a-491a(a) of the Connecticut General Statutes; or
    - (D) A material misstatement of fact is made on an initial or renewal application.
  - (2) Subject to subsection (c)(1) of this section, the commissioner may issue a license or renewal of a license to operate the hospice inpatient facility if the commissioner determines that a hospice inpatient facility is in compliance with the statutes and regulations pertaining to its licensure. The license shall be for a period not to exceed two years.
  - (3) Each facility providing hospice care not physically connected to a licensed hospice inpatient facility, shall require its own license.
  - (4) The Commissioner shall issue a license to the hospice inpatient facility in the name of the owner of the hospice inpatient facility or legal entity appearing on the application. The license shall not be transferable or assignable.
  - (5) Each license shall specify:
    - (A) The maximum licensed bed capacity; and
    - (B) The names of the administrator, medical director and director of nurses; and
    - (C) Any provisional waivers of the Regulations of Connecticut State Agencies that have been granted to the hospice inpatient facility.
  - (6) Notice to public. The licensee shall post the license in a conspicuous place in the lobby or reception room of the facility.
  - (7) Change in status. Change in ownership, level of care, number of beds or location shall require a new license to be issued. The licensee shall notify the department in writing no later than ninety days prior to any such proposed change. For purposes of this subdivision, any change in the ownership of a hospice inpatient facility, owned by a person, group of persons, organization, institution or agency, public or private, partnership or association or the

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change in ownership or beneficial ownership of ten per cent or more of the stock of a corporation that owns, conducts, operates or maintains such hospice inpatient facility, shall be subject to prior approval of the department after a scheduled inspection of such hospice inpatient facility is conducted by the department, provided such approval shall be conditioned upon a showing by such hospice inpatient facility to the commissioner that it has complied with all regulatory requirements. Any such change in ownership or beneficial ownership resulting in a transfer to a person related by blood or marriage to such an owner or beneficial owner shall not be subject to prior approval of the department unless: (A) Ownership or beneficial ownership of ten per cent or more of the stock of a corporation, partnership or association that owns, conducts, operates or maintains more than one hospice inpatient facility is transferred; (B) ownership or beneficial ownership is transferred in more than one hospice inpatient facility; or (C) the hospice inpatient facility is the subject of a pending complaint, investigation or licensure action. If the hospice inpatient facility is not in compliance, the commissioner may require the new owner to sign a consent order providing reasonable assurances that the violations shall be corrected within a specified period of time. Notice of any such proposed change of ownership shall be given to the department at least ninety days prior to the effective date of such proposed change. For the purposes of this subdivision, "a person related by blood or marriage" means a parent, spouse, child, brother, sister, aunt, uncle, niece or nephew. For the purposes of this subdivision, a change in the legal form of the ownership entity, including, but not limited to, changes from a corporation to a limited liability company, a partnership to a limited liability partnership, a sole proprietorship to a corporation and similar changes, shall not be considered a change of ownership if the beneficial ownership remains unchanged and the owner provides such information regarding the change to the department as may be required by the department in order to properly identify the current status of ownership and beneficial ownership of the facility or institution. For the purposes of this subdivision, a public offering of the stock of any corporation that owns, conducts, operates or maintains any hospice inpatient facility shall not be considered a change in ownership or beneficial ownership of such hospice inpatient facility if the licensee and the officers and directors of such corporation remain unchanged, such public offering cannot result in an individual or entity owning ten per cent or more of the stock of such corporation, and the owner provides such information to the department as may be required by the department in order to properly identify the current status of ownership and beneficial ownership of the hospice inpatient facility.

- (8) Change in personnel. The governing authority shall notify the department immediately, and shall confirm in writing not more than five days after such notification to the department, of both the resignation or removal and the subsequent appointment of the hospice inpatient facility's administrator, medical director, or director of nurses.
- (9) Failure to grant the department immediate access to the hospice inpatient facility or to the hospice inpatient facility's records shall be grounds for denial or revocation of the hospice inpatient facility's license.

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- (10) Surrender of license. The administrator shall directly notify each patient or patient representative concerned, the patient's family, the patient's primary physician, and any third party payers concerned at least thirty days prior to the voluntary surrender of the hospice inpatient facility's license or surrender of license upon the department's order of revocation, refusal to renew or suspension of license. In such cases, the license shall be surrendered to the department no later than seven days after the termination of operation.
- (d) Waiver.
- (1) The commissioner may waive provisions of these regulations if the commissioner determines that such waiver would not endanger the health, safety or welfare of any patient. The commissioner may impose conditions upon granting the waiver that assure the health, safety and welfare of patients, or may revoke the waiver upon a finding that the health, safety, or welfare of any patient has been jeopardized. The commissioner may grant a waiver for a specified period of time subject to renewal in the commissioner's discretion. The licensee may seek renewal of the waiver by submitting the required written documentation specified in subsection (d)(2) of this section.
  - (2) The licensee requesting a waiver shall do so in writing to the department. Such request shall include:
    - (A) The specific regulations for which the waiver is requested;
    - (B) Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon enforcement of the regulations;
    - (C) The specific relief requested;
    - (D) Any documentation that supports the request for waiver; and
    - (E) Alternative policies and procedures proposed.
  - (3) In consideration of any request for waiver, the commissioner may consider:
    - (A) The level of care provided;
    - (B) The maximum patient capacity;
    - (C) The impact of a waiver on care provided; and
    - (D) Alternative policies or procedures proposed.
  - (4) The Department reserves the right to request additional information before processing the request for waiver.

### Section 19a-495-6c Governing Authority

- (a) A governing authority shall be established by the licensee for the hospice inpatient facility.
- (b) The governing authority shall have the authority and responsibility for the overall management and operation of the hospice inpatient facility and shall adopt bylaws or rules that are periodically reviewed and a notation made of the date of such adoption and review. Such bylaws or rules shall include, but not be limited to:
  - (1) A mission statement and purpose of the hospice inpatient facility;
  - (2) Delineation of the powers, duties and voting procedures of the governing authority, its officers and committees;
  - (3) Qualifications for membership, method of selection and terms of office of members and chairpersons of committees;
  - (4) A description of the authority delegated to the administrator;

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- (5) The conflict of interest policy and procedures;
  - (6) Scope of services offered;
  - (7) Admission and discharge criteria;
  - (8) Medical and dental supervision and plans of treatment;
  - (9) Clinical records;
  - (10) Personnel qualifications;
  - (11) Annual review of personnel policies;
  - (12) Adoption of written policies assuring the protection of patients' rights and patient grievance procedures, a description of which shall be posted conspicuously in the hospice inpatient facility and distributed personally to each patient upon admission; and
  - (13) Determination of the frequency of meetings of the governing authority.
- (c) The bylaws or rules shall be available to all members of the governing authority and the administrator.
- (d) The governing authority shall:
- (1) Meet as frequently as necessary to fulfill its responsibilities;
  - (2) Provide a written agenda and minutes for each meeting;
  - (3) For each meeting, provide minutes that include, but are not limited to, the identity of those members in attendance, reports of the quality assessment and performance improvement program and any patient grievances. Such minutes shall be approved by the governing authority and dated and signed by the secretary; and
  - (4) Ensure that the agenda and minutes of any of its meetings or any of its committees are available at any time to the commissioner..
- (e) Other specific responsibilities of the governing authority shall include, but not be limited to:
- (1) Oversight of the management and operation of the hospice inpatient facility;
  - (2) Oversight of the financial viability and management of the hospice inpatient facility's fiscal affairs;
  - (3) Adoption and documented annual review of written bylaws and budget;
  - (4) Services provided by the hospice inpatient facility and the quality of care rendered to patients and their families;
  - (5) Provision of a safe physical plant equipped and staffed to maintain the hospice inpatient facility and services in accordance with any applicable local and state regulations and any federal regulations that may apply to federal programs in which the hospice inpatient facility participates;
  - (6) Appointment of a qualified administrator;
  - (7) Approval of the administrator's appointment of a medical director;
  - (8) Approval of an organizational chart that establishes clear lines of responsibility and authority in all matters relating to management and maintenance of the facility and patient care;
  - (9) Annual review and update of the operation and fiscal plan, including anticipated needs, income and expenses;
  - (10) Establish and maintain the quality assessment and performance improvement program including, but not limited to, the selection and appointment of a quality assessment and performance improvement advisory committee; review

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- of issues, corrective actions and outcomes; and recommendations for improvement;
- (11) Policy and program determination and delegation of authority to implement policies and programs. The establishment of such policies shall include, but not be limited to:
    - (A) Responsibilities of the administrator and the medical director;
    - (B) Conflict of interest on the part of the governing authority, professional staff and employees;
    - (C) Services to be provided;
    - (D) Criteria for the selection, admission and transfer of terminally ill patients and families;
    - (E) Patient or family consent and involvement in the development of patient centered plan of care;
    - (F) Developing a support network when the family is not available and the patient needs and wants that support;
    - (G) Referrals and coordination with community and other health care facilities or agencies that shall include but not be limited to a mechanism for recording, transmitting and receiving information essential to the continuity of patient care. Such information shall include, but not be limited to:
      - (i) Patient identification data including name, address, age, gender, name of representative, and health insurance coverage;
      - (ii) Diagnosis and prognosis, medical status of patient, brief description of current illness, medical and nursing plans of care including information such as drugs and biological products, treatments, dietary needs, baseline laboratory data;
      - (iii) Functional status;
      - (iv) Special services such as physical therapy, occupational therapy, speech and language therapy, and any other therapy; and
      - (v) Psychosocial needs.
    - (H) Professional management responsibilities for contracted services;
    - (I) Reports of patient's condition and procedures for the transmission of such reports to the patient's physician;
    - (J) Provisions governing the relationship of the attending physician or the advanced practice registered nurse to the medical director, and the interdisciplinary team; and
    - (K) Such other matters, as may be relevant to the organization and operation of hospice care.
  - (12) Ensure that any and all services provided by hospice inpatient facility volunteers and direct service staff are consistent with accepted standards of practice and applicable law;
  - (13) Maintain an active quality assessment and performance improvement committee and provide any and all services offered in compliance with sections 19a-495-6a to 19a-495-6m, inclusive of the Regulations of Connecticut State Agencies; and
  - (14) Compliance with any established hospice inpatient facility policy.

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(f) Failure of the administrator to implement the bylaws, rules, policies, or programs adopted by the governing authority shall be grounds for disciplinary action against the licensee under section 19a-494 of the Connecticut General Statutes.

### Section 19a-495-6d Administration

- (a) The governing authority shall appoint a full-time administrator, who possesses:
- (1) A master's degree in nursing with an active license to practice nursing in this state and not less than one year of supervisory or administrative experience in a health care facility program which included care of the sick;
  - (2) A master's degree in public health or administration with a concentration of study in health services administration or social work, and not less than one year of supervisory or administrative experience in a health care facility or program which included care of the sick;
  - (3) A baccalaureate degree in nursing or a related field with an active license to practice nursing in this state and not less than two years supervisory or administrative experience in a health care facility or program which included care of the sick;
  - (4) A baccalaureate degree in administration with a concentration of study in health services administration and not less than two years supervisory or administrative experience in a health care facility or program which included care of the sick; or
  - (5) A license to practice medicine in accordance with chapter 370 of the Connecticut General Statutes and not less than one year supervisory or administrative experience in a health care facility or program which included care of the sick.
- (b) The administrator shall:
- (1) Implement the bylaws, rules, policies and programs adopted by the governing authority;
  - (2) Coordinate the activities between the governing authority and the professional staff;
  - (3) Ensure the hospice inpatient facility's compliance with all local, state and federal laws and regulations that may apply to programs in which the facility participates;
  - (4) Ensure that there are sufficient qualified staff and services available to meet the needs of patients at all times; and
  - (5) Obtain a criminal history and patient abuse background search pursuant to section 19a-491c of the Connecticut General Statutes for all employees and volunteers that have direct patient contact or access to patient records within three months from the date of employment for all states the employee has lived or worked in for the past three years; and shall ensure all contractors obtain the same for staff providing direct patient services.
- (c) The administrator, with the approval of the governing authority, shall appoint a medical director who is licensed as a physician, with experience and training in hospice care. The medical director shall be designated by the hospice inpatient facility and be responsible for the coordination and oversight of medical services provided by the hospice inpatient facility.
- (1) The medical director shall have the responsibility for:

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- (A) Coordination and oversight of medical care and services provided;
  - (B) Ensuring and maintaining quality standards of professional practice;
  - (C) Implementation of patient care policies;
  - (D) The achievement and maintenance of quality assurance of professional practices through a mechanism for the assessment of patient and family care outcomes;
  - (E) Ensuring completion of health care worker screening and immunization requirements;
  - (F) Certification of patients admitted to the program;
  - (G) Participation as a member of the interdisciplinary team, in the development, implementation and assessment of patient centered plans of care;
  - (H) Consulting with licensed independent professionals regarding patient care plans; and
  - (I) Identifying a designee who is a licensed independent practitioner. The designee shall assume the same responsibilities and obligations as the medical director when the medical director is temporarily not available.
- (2) The medical director shall be available for consultation on a twenty-four hour basis and shall be on site at the hospice inpatient facility a sufficient number of hours to meet the responsibilities described in subparagraphs (1) (A) to (1) (I), inclusive of this subsection.
- (d) The administrator shall appoint a full-time director of nurses who is licensed as a registered nurse and possesses a baccalaureate degree in nursing with coursework or experience in hospice care. The director of nurses shall have the following qualifications:
- (1) A master's degree from a program approved by the Commission on Collegiate Nursing Education or the American Public Health Association with not less than two years' full-time clinical experience or community health program; or
  - (2) Not less than three years of full-time clinical experience in nursing, at least two of which were in a hospice, home health agency or community health program.
- (e) The director of nurses shall be responsible for the overall hospice inpatient facility's nursing services, which shall include:
- (1) Coordination of professional and non-professional nursing services provided;
  - (2) Ensuring and maintaining quality standards of professional practice;
  - (3) Development and implementation of patient care policies;
  - (4) Participation in the development and implementation of the patient centered plans of care;
  - (5) Consulting with other interdisciplinary team members regarding patient care; and
  - (6) Development and implementation of the hospice inpatient facility infection control and hospice inpatient facility safety policies.
- (f) Except for a hospice inpatient facility with twelve licensed beds or less, the administrator shall not serve as the director of nurses.
- (g) There shall be a written agreement for the provision of services if provided by a contractor and not directly by the licensee. The Commissioner shall have access to the records of the contractor related to performance of the agreement and the

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provision of services. The agreement shall clearly delineate the responsibilities of the contractor and licensee and shall include but not be limited to the following provisions:

- (1) A stipulation that services may be provided only with the express authorization of the licensee;
  - (2) A stipulation that the licensee is responsible for the admission of patients;
  - (3) Identification of services to be provided by the contractor that shall be within the scope and limitations set forth in the patient centered plan of care and shall not be altered by the contractor in type, amount, frequency or duration;
  - (4) Manner in which the contracted services are coordinated, supervised and evaluated by the governing authority of the hospice inpatient facility;
  - (5) Assurance of compliance with the patient care policies of the licensed licensee;
  - (6) Establishment of procedures for and frequency of patient and family care assessment;
  - (7) Furnishing the patient centered plan of care to other health care facilities upon transfer of patient;
  - (8) Assurance that the qualifications of the personnel and services to be provided meet the requirements of sections 19a-495-6a to 19a-495m, inclusive, of the Regulations of Connecticut State Agencies, including licensure, personnel qualifications, functions, supervision, hospice training and orientation, in-service training, and attendance at case conferences;
  - (9) Reimbursement mechanism, charges, and terms for the renewal or termination of the agreement;
  - (10) Such other provisions as may be mutually agreed upon or as may be relevant and deemed necessary;
  - (11) Assurance that the medical record shall include a record of all services and events, and a copy of the discharge summary and, that, if requested, a copy of the medical record shall be provided to the licensee; and
  - (12) The party responsible for the implementation of the provisions of the agreement.
- (h) The licensee shall retain responsibility for contracted services and ensure such services are rendered in accordance with accepted standards of practice and applicable law.
- (i) A medical record shall be maintained for every patient who is evaluated or treated at a hospice inpatient facility. The medical records shall be:
- (1) Safeguarded against loss, destruction or unauthorized use, and all entries in the patient's medical record shall be written in ink and legible. Electronic medical records shall be consistent with state and federal applicable law, policies and procedures for interoperability, privacy and security.
  - (2) Started at the time of admission with identification, date, and a nurse's notation of condition on admission. Within twenty-four hours of admission, the attending practitioner shall add an admission note and orders. The attending practitioner shall record the patient's complete history and physical examination within twenty-four hours of admission, unless the patient's primary provider performed the patient's last history and physical examination within the last thirty days and is following the patient. In such case, the

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patient's last history and physical examination shall be noted in the medical record and a copy of that history and physical examination shall become part of the medical record.

- (3) Prepared accurately and entries completed promptly with sufficient information and progress notes to justify the diagnosis and warrant the treatment and palliation. Physician's orders, nurses' notes and notes from other disciplines including, but not limited to, pastoral, contractor, nurse aide and volunteers, shall be kept current in a professional manner and all entries shall be signed by the person responsible for making the order or note and such person's title.
- (4) Kept confidential and secured. Written consent of the patient or the patient's representative shall be required for release of medical information or medical records unless otherwise provided by law.
- (5) The records shall be filed and stored in an accessible manner and shall be kept for not less than seven years after discharge of patients, except that original medical records may be destroyed sooner if they are electronically preserved by a accepted mechanism for medical records.
- (6) Completion of the patient's medical records shall be accomplished no later than thirty days after discharge or no later than thirty days of death.

### Section 19a-495-6e General Requirements

- (a) Core services provided directly by the licensee shall, except as provided in subsection (b) of this section, include the following:
  - (1) Services of a physician or advanced practice registered nurse;
  - (2) Nursing services provided by a registered nurse, or licensed practical nurse;
  - (3) Social services;
  - (4) Counseling services if required;
  - (5) Pain assessment and management; and
  - (6) Availability of drugs and biological products on a twenty-four hour basis.
- (b) The licensee may use contracted services to supplement the hospice inpatient facility's staff under extraordinary circumstances when it is necessary to meet the needs of the patients. If contractors are used, the licensee shall maintain responsibility for the services and shall assure that the qualifications of staff and services provided meet the requirements of the Regulations of Connecticut State Agencies and relevant Connecticut General Statutes. When a contractor is providing services during an outpatient admission, the licensee and contractor shall have a "Coordination of Outpatient Services Agreement" in place for the provision of services which includes, but is not limited to:
  - (1) A criminal history and patient abuse background search pursuant to section 19a-491c of the Connecticut General Statutes including, but not limited to, all hospice inpatient facility employees or contracted employees and volunteers who have direct patient contact or access to patient records;
  - (2) Mechanisms for the collaboration and coordination of care; and
  - (3) The exchange of information to meet the ongoing needs of the patient and family;
- (c) In addition to the core services, the licensee shall ensure that the following services are provided, as needed, directly by the licensee or by a contractor under written agreement with the licensee:

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- (1) Home health aide and homemaker services;
  - (2) Short-term respite care and general inpatient care;
  - (3) Physical therapy, occupational therapy, and speech and language pathology services;
  - (4) Medical supplies and appliances;
  - (5) Nutrition counseling;
  - (6) Complementary therapies; and
  - (7) Any other services identified in the patient centered plan of care.
- (d) The licensee shall make services available as follows:
- (1) Nursing services, physician services, drugs and biological products continuously available on a twenty-four hour basis;
  - (2) All other services available on a twenty-four hour basis to the extent necessary and reasonable to meet the needs of the patient care for the palliation and management of the patient's terminal illness and related conditions in accordance with the patient centered plan of care;
  - (3) Assessment capability available on a twenty-four hour basis to respond to acute and urgent patient or family needs; and
  - (4) Additional health services or related services may be provided as deemed appropriate to meet the patient's and family's needs, and all services shall be rendered in a manner consistent with accepted standards of practice and applicable law.
- (e) The licensee shall ensure patient accessibility to the following:
- (1) A functioning system that enables inpatients or outpatients and their families to make telephone contact with hospice inpatient facility staff on a twenty-four hour basis. Mechanical answering devices shall not be acceptable;
  - (2) A system that provides twenty-four hour, pharmacy services for the palliative care and management of the patient; and
  - (3) A system that ensures that patients are permitted to receive visitors, including small children and pets, at any hour, provided that a therapeutic environment is maintained.
- (f) The licensee shall ensure the continuity of patient and family care through adoption and implementation of written policies, procedures and criteria providing for the following:
- (1) Coordination of community physicians and nurses with hospice inpatient facility staff prior to and at the time of admission;
  - (2) Admission criteria for the initial assessment of the patient or family needs and decision for care;
  - (3) Signed informed consent;
  - (4) Ongoing assessment of the patient's and family's needs;
  - (5) Development and review of the patient centered plan of care by the interdisciplinary team;
  - (6) Transfer of patients to inpatient care facilities for inpatient respite care or general inpatient care;
  - (7) The provision of appropriate patient and family information at the point of transfer between care settings;
  - (8) Community or other resources to ensure continuity of care and to meet patient and family needs;

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- (9) Management of pain and symptom control through palliative care and utilization of therapeutic services; and
- (10) Constraints imposed by limitations of services or family conditions and such other criteria as may be deemed appropriate for each patient and family.

#### Section 19a-495-6f Hospice Inpatient Facility Services

- (a) The licensee shall provide staff in sufficient numbers and services of sufficient duration to meet the physical, psychosocial and spiritual needs of patients and their families. The licensee is responsible for ensuring that staffing for all services reflect its volume of patients, their acuity, and the level of intensity of services needed to ensure that the plan of care outcomes are achieved and negative outcomes are avoided.
- (b) The licensee shall provide quality care through the provision of the following services:
  - (1) Physical, occupational, and speech and language therapy shall be available and when provided, such services shall be rendered by a licensed person in accordance with the patient centered plan of care and in a manner consistent with accepted standards of practice and applicable law.
  - (2) Attending practitioner services shall be provided by a licensed physician or advanced practice registered nurse to meet the medical needs of patients for the management of the terminal illness and related conditions, through palliative and supportive care. Attending practitioner services shall be provided in accordance with hospice inpatient facility policies in a manner consistent with accepted standards of practice and applicable law. In addition to palliation and management of terminal illness and related conditions, physicians and advanced practice registered nurses that are part of the staff of the hospice inpatient facility or members of the interdisciplinary team, shall meet the medical needs of the patients to the extent that these needs are not met by the attending practitioner.
  - (3) Bereavement counseling services shall be provided to meet the needs of the family both before and after the death of the patient.
  - (4) Dietary counseling services for the patient and family shall be available as may be required, while the patient is in hospice care.
  - (5) Dietary services shall be provided to patients, under the direction of a food service supervisor, who is a qualified food operator as defined in section 19-13-B42 of the Regulations of Connecticut State Agencies. The food services supervisor shall:
    - (A) Ensure the dietary services operation complies with all applicable state regulations and statutes;
    - (B) Employ an adequate number of individuals to perform the duties and responsibilities of the food service operation; and
    - (C) Consult with a registered dietician on a regular basis, and an advanced practice registered nurse, or physician concerning patients' diets, as necessary.
  - (6) Medical supply services including, but not limited to, appliances, drugs and biological products as may be needed, shall be provided for the palliation and management of the patients' terminal illness.

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- (7) Nursing assistants shall provide personal care and other related support services under the delegation and supervision of a registered nurse. Duties of nursing assistants shall include, but not be limited to:
  - (A) Personal care;
  - (B) Ambulation and exercise;
  - (C) Assisting a patient with eating;
  - (D) Reporting changes in a patient's condition and needs;
  - (E) Completing a patient's medical records as directed; and
  - (F) Assisting with the patient's self-administration of drugs and biological products by:
    - (i) Reminding a patient to self-administer the drugs or biological products;
    - (ii) Verifying that a patient has self-administered their drugs or biological products;
    - (iii) Opening bottles, bubble packs or other forms of packaging if the patient is not capable of performing this function.
- (8) Nursing services shall be provided under the direction of a licensed registered nurse to meet the nursing care needs of the patient and family, as identified in the patient centered plan of care. Nursing services shall be provided in accordance with accepted standards of practice, applicable law and hospice inpatient facility policies. There shall be a registered nurse on the premises on a twenty-four hour basis and there shall be a sufficient number of nursing personnel on a twenty-four hour basis to:
  - (A) Assess patients' needs;
  - (B) Assist in the development and implementation of patient centered plans of care;
  - (C) Provide direct patient care services; and
  - (D) Coordinate or perform other related activities to maintain the health and safety of the patients.
- (9) Pharmacy services shall be provided under the direction of a licensed pharmacist who is an employee of or has a written agreement with the hospice inpatient facility. Duties of the pharmacist shall include, but not be limited to the following:
  - (A) Identification of potential adverse drug reactions, and recommended appropriate corrective action;
  - (B) Compounding, packaging, labeling, dispensing, and distributing all drugs to be administered to patients;
  - (C) Monitoring patient drug therapy for potential drug interactions and incompatibilities at least monthly with documentation of same;
  - (D) Inspecting all areas within the facility where drugs (including emergency supplies) are stored at least monthly to assure that all drugs are properly labeled, stored and controlled; and
  - (E) Serving as a consultant to the interdisciplinary team for pain control and symptom management.
- (10) Spiritual counseling services shall be provided in accordance with the wishes of the patient as noted in the patient centered plan of care. Services may include, but not be limited to:

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- (A) Communication and support from a spiritual counselor;
  - (B) Consultation and education for the patient, family and interdisciplinary team members.
- (11) Social work services shall be provided as identified in the patient centered plan of care and in accordance with accepted standards of practice, applicable law and hospice inpatient facility policies. The social worker's functions shall include, but not be limited to:
- (A) Comprehensive evaluation of the psychosocial status of the patient and family as it relates to the patient's illness and environment;
  - (B) Counseling of the patient, family and primary caregivers;
  - (C) Participation in development of the patient centered plan of care; and
  - (D) Participation in ongoing case management with the hospice inpatient facility inter-disciplinary team.
- (12) Volunteer Services shall be provided under the supervision of designated hospice inpatient facility employees.
- (A) Volunteers may provide administrative services or non-direct patient care services under the supervision of designated hospice inpatient facility employees;
  - (B) Direct patient care services may be provided by licensed or registered volunteers who meet the requirements for the provision of such services, under the supervision of appropriate, licensed hospice inpatient facility employees;
  - (C) The licensee shall provide and document a volunteer orientation and training program for each volunteer;
  - (D) Volunteer services involving any direct patient care services shall be provided in accordance with the patient centered plan of care.

### Section 19a-495-6g In-service Training and Education

- (a) In-service educational programs shall be conducted. Such programs shall include but not be limited to:
- (1) An orientation program for new personnel, volunteers and contracted staff who provide care to hospice inpatient facility patients. The orientation program shall be provided before the start of employment, volunteering, or provision of contract services at the hospice inpatient facility. The orientation program shall address:
    - (A) The purpose, goals, mission and philosophy of hospice care; and
    - (B) Each individual's specific duties.
  - (2) Not less than once a year, a training program for employees, volunteers and contracted staff who provide care to hospice inpatient facility patients concerning the development and improvement of hospice-related skills that are identified by the quality assessment and performance improvement program;
  - (3) Annual training for all employees of the hospice inpatient facility, volunteers and contracted staff in:
    - (A) Prevention and control of infection;
    - (B) Patient rights and confidentiality;
    - (C) Fire prevention and safety; and

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- (D) Food services and sanitation.
- (b) The administrator shall assess the skills and competency of all individuals providing patient care and, as necessary, provide in-service training.
- (c) The administrator shall maintain documentation and an attendance list of all in-service programs and education for a period of three years after completion.

### Section 19a-495-6h Patient Rights and Hospice Inpatient Facility Responsibilities

- (a) The licensee shall have a written bill of rights and responsibilities governing services, which shall be provided and explained to each patient, family or representative at the time of admission. The medical record of each patient shall contain documentation of compliance with this provision.
  - (1) The patient's rights and responsibilities shall include, but are not limited to:
    - (A) Be afforded considerate and respectful care;
    - (B) Receive effective pain management and symptom control on a twenty-four hour basis for the palliation and management of the terminal illness and related conditions;
    - (C) Be involved in the development of the patient centered plan of care;
    - (D) Be fully informed of one's condition;
    - (E) Refuse care or treatment;
    - (F) Choose an attending physician;
    - (G) Have a confidential medical record;
    - (H) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property;
    - (I) Receive information about the services covered under the hospice benefits, which shall include but not be limited to a description of available services, unit charges and billing mechanisms;
    - (J) Receive information about the scope of services that the hospice inpatient facility shall provide and specific limitations on those services including, but not limited to, the hospice inpatient facility's policy on uncompensated care and criteria for admission to and discharge from service;
    - (K) Receive an explanation of the grievance procedure and the right to file a grievance without discrimination or reprisal regarding treatment or care to be provided or regarding the lack of respect for property by anyone providing hospice care;
    - (L) Receive information concerning the procedure for registering complaints with the commissioner and information regarding the availability of the Medicare toll-free hotline, including telephone number, hours of operation for receiving complaints; and
    - (M) Be free from unnecessary restraint and seclusion.
- (b) The licensee shall ensure compliance with subsection (a) of this section and shall:
  - (1) Immediately investigate all complaints made by a patient, family, representative, hospice inpatient facility employee, volunteer or contractor regarding the quality or appropriateness of treatment or care provided to a patient;

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- (2) Ensure that any employee or volunteer of the hospice inpatient facility or any contractor having reasonable cause to suspect or believe that a patient has been abused, neglected or mistreated reports the abuse, neglect or mistreatment to the administrator and Department. An oral report to the administrator shall be made immediately. A written report to the administrator and Department shall be made as soon as practicable but no later than twenty-four hours after said employee, volunteer or contractor has reasonable cause to suspect or believe that a patient has been abused, neglected or mistreated;
  - (3) Ensure that all allegations of patient abuse, neglect or mistreatment are thoroughly investigated. Such investigation shall be initiated within twenty-four hours of the oral report and concluded within five days of receipt of the written report;
  - (4) Ensure that any further potential abuse, neglect or mistreatment has been prevented while the investigation is in progress; and
  - (5) Report the results of all investigations to the Department not more than five days after the investigation has concluded.
- (c) Unanticipated events resulting in hospitalization or death of any patient shall be immediately investigated and reported to the administrator and Department within twenty-four hours. All patient deaths occurring within the hospice inpatient facility that are suspicious or unnatural, including, but not limited to, trauma, a drug overdose, poisoning, or an infectious disease with epidemic potential shall immediately be reported to the hospice inpatient facility's administrator and the Department.

#### Section 19a-495-6i Quality Assessment and Performance Improvement

- (a) The licensee shall implement the quality assessment and performance improvement program established by the governing authority that includes all patient care disciplines and services provided, including those services provided by a contractor, throughout the hospice inpatient facility. The governing authority shall ensure that the program reflects the complexity of its organization and services, involves leadership working with input from facility staff, patients and families, involves all hospice inpatient facility services including those furnished under contract or arrangement, focuses on performance indicators to monitor a wide range of care processes and outcomes related to palliative care, and initiates actions to demonstrate improvement in hospice inpatient facility performance and promote sustained improvement.
- (b) Such plan and program shall be ongoing and shall include:
  - (1) Oversight responsibility and program objectives;
  - (2) The use of quality indicator data to assess and monitor patient care and services;
  - (3) Evidenced based practices and policies for:
    - (A) Pain and symptom management;
    - (B) The prevention and treatment of pressure sores;
    - (C) The prevention of abuse, neglect and mistreatment;
    - (D) The prevention of accidents and injuries; and
    - (E) The prevention, surveillance and control of health care associated infections and communicable diseases.
  - (4) A method and mechanism for identifying, and as required, reporting:

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- (A) Infectious and communicable disease occurrences among patients and personnel;
  - (B) Health care associated infections and a plan for the implementation of actions that are expected to result in improvement and disease prevention;
  - (C) Adverse events; and
  - (D) Potential sources of injuries and medical errors and a plan for the implementation of actions that are expected to result in improvement and prevention of such occurrences.
- (5) Review and investigation of all adverse events;
  - (6) Other criteria and data necessary to monitor the quality of patient care; and
  - (7) Evidence based practices to identify, evaluate, and correct problems.
- (c) The hospice inpatient facility administrator shall designate a licensed employee to coordinate and manage the quality assessment and performance improvement program. The licensed employee shall ensure that:
- (1) Program activities focus on high risk, high volume, or problem-prone areas;
  - (2) The program maintains records of appropriate corrective action to address problems identified through the quality assessment and performance improvement program; and
  - (3) The outcome of the corrective action is documented and submitted to the governing authority for its review.
- (d) The members of the quality assessment and performance improvement committee members as described in section 19a-495-6c(e)(10) of the Regulations of Connecticut State Agencies shall be employees of the hospice inpatient facility and shall include at least one licensed independent practitioner, one registered nurse, and spiritual counselor.
- (e) The functions of the quality assessment and performance improvement committee shall be to:
- (1) Monitor the effectiveness and safety of services and quality of care;
  - (2) Identify opportunities for improvement;
  - (3) Recommend the frequency and detail of data collection to the governing authority;
  - (4) Develop, implement and evaluate performance improvement projects based on the hospice inpatient facility's population and needs that reflect the scope, complexity and past performance of the hospice inpatient facility's services and operations;
  - (5) Ensure there is a rationale as well as a goal and measurable objectives for each project that is implemented;
  - (6) Ensure progress is documented for each project;
  - (7) At least annually review and recommend to the governing authority revisions to the hospice inpatient facility's policies relating to:
    - (A) Quality assessment and improvement activities;
    - (B) Standards of care;
    - (C) Professional issues especially as they relate to the delivery of services and findings of the quality assessment and improvement program.
- (f) The quality assessment and performance improvement committee shall meet at least twice per year and shall maintain records of all quality improvement activities.

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- (g) Written minutes shall document dates of meetings, attendance, agenda and recommendations. The minutes shall be presented, reviewed, and accepted at the next regular meeting of the governing authority of the hospice inpatient facility following the quality assessment and performance improvement committee meeting. These minutes shall be available upon request to the commissioner.

#### Section 19a-495-6j Assessment and Patient Centered Plan of Care

- (a) At the time of admission, an initial assessment shall be completed by a licensed registered nurse to identify and meet the immediate needs of the patient. Within forty-eight hours of a patient's admission, a licensed registered nurse shall complete the assessment to evaluate the patient's immediate physical, psychosocial, emotional, and spiritual status.
- (b) Not later than five days after a patient's admission to the hospice inpatient facility, the interdisciplinary team shall complete a comprehensive assessment for the patient that shall include but not be limited to the following:
  - (1) History of pain, symptoms, and treatment;
  - (2) Characteristics of pain and symptoms;
  - (3) Physical examination;
  - (4) Current medical conditions and drugs and biological products;
  - (5) Patient or family's goal for pain and symptom management;
  - (6) Condition causing admission;
  - (7) Relevant history as well as complications and risk factors that affect care planning;
  - (8) Functional status;
  - (9) Imminence of death;
  - (10) Severity of symptoms;
  - (11) Drug profile;
  - (12) Bereavement;
  - (13) The need for referrals or further evaluation by appropriate health professionals; and
  - (14) Data elements that allow for the measurement of patient outcomes and are related to aspects of care.
- (c) The comprehensive assessment shall be updated as frequently as the condition of the patient requires, but not less than once every fourteen calendar days.
- (d) Upon completion or update of the comprehensive assessment, a written patient centered plan of care shall be established or revised for the patient.
- (e) Such patient centered plan of care shall be developed to include only those services that are acceptable to the patient and family.
- (f) The patient and family shall be involved whenever possible in the implementation and continuous assessment of the patient centered plan of care.
- (g) The interdisciplinary team shall ensure that the patient and family receive education and training provided by the licensee regarding the responsibilities of the patient and family for the care and services identified in the patient centered plan of care.
- (h) The patient centered plan of care shall include, but not be limited to:
  - (1) Pertinent diagnosis and prognosis;
  - (2) Interventions to facilitate the management of pain and other symptoms;

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- (3) Measurable targeted outcomes anticipated from implementing and coordinating the patient centered plan of care;
  - (4) A detailed statement of the patient and family needs addressing the:
    - (A) Physical, psychological, social, and spiritual needs;
    - (B) The scope of services required;
    - (C) The frequency of services;
    - (D) The need for respite or general inpatient care;
    - (E) Nutritional needs;
    - (F) Drugs and biological products;
    - (G) Management of pain and control of other symptoms; and
    - (H) Management of grief.
  - (5) Drugs and treatments necessary to meet the needs of the patient;
  - (6) Medical supplies and appliances necessary to meet the needs of the patient;
  - (7) The interdisciplinary team's documentation of the patient's and family's understanding, involvement, and agreement with the patient centered plan of care; and
  - (8) Such other relevant modalities of care and services as may be appropriate to meet individual patient and family care needs.
- (i) The patient centered plan of care shall be reviewed and updated by the interdisciplinary team as needed, but not less than once every fourteen calendar days. This review and update shall be documented in the medical record.
  - (j) A revised patient centered plan of care shall include information from the patient's updated comprehensive assessment and the patient's progress toward outcomes specified in the patient centered plan of care.

#### Section 19a-495-6k Drugs and Biological Products

- (a) The interdisciplinary team shall confer with a licensed pharmacist or independent practitioner with education and training in drug management, who is an employee of or has a written agreement with the licensee, to ensure that drugs and biological products meet the patient's needs on a twenty-four hour basis.
- (b) Only a licensed independent practitioner shall order drugs and biological products for the patient, in accordance with the patient centered plan of care.
  - (1) The written or electronic order shall only be given to a registered nurse, advanced practice registered nurse, physician assistant, pharmacist, or physician; and
  - (2) If the drug order is verbal, the registered nurse, advanced practice registered nurse, pharmacist, or physician receiving the order shall record, read back and sign it immediately, and have the prescribing person sign the order in accordance with state and federal regulations and statutes.
- (c) The licensee shall ensure that:
  - (1) Drugs and biological products are obtained from community or institutional pharmacies or establish its own institutional pharmacy licensed by the Department of Consumer Protection in accordance with section 20-594 of the Connecticut General Statutes;
  - (2) A written policy is in place that promotes dispensing accuracy;
  - (3) Current and accurate records of the receipt and disposition of all controlled drugs are maintained; and

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- (4) Drugs and biological products are only administered to patients by a licensed nurse, physician's assistant, or licensed independent practitioner consistent with accepted standards of practice and applicable law.
- (d) Drugs and biological products shall be labeled in accordance with currently accepted professional practice and shall include appropriate usage and cautionary instructions, as well as an expiration date.
- (e) Drugs and biological products shall be stored in a secure area. Controlled drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1976 shall be stored in locked compartments within such secure storage areas. Only personnel authorized to administer controlled drugs shall have access to the locked areas.
- (f) Controlled drugs shall be disposed of in compliance with the hospice inpatient facility policy and in accordance with state and federal requirements.
- (g) Discrepancies in the acquisition, storage, dispensing, administration, disposal, or return of controlled drugs shall be investigated immediately by the pharmacist and administrator, and where required, reported to the appropriate state authority. A written account of the investigation shall be made available to state and federal officials as required by law.

### Section 19a-495-6l Medical Supplies and Durable Equipment

- (a) The licensee shall:
  - (1) Comply with manufacturer recommendations for performing routine and preventive maintenance on durable medical equipment; and
  - (2) Develop routine repair and maintenance policies when a manufacturer recommendation does not exist for such durable medical equipment.
- (b) All durable medical equipment shall be safe and work as intended for use in the patient's environment.
- (c) The licensee shall ensure that the patient, family, and any other caregiver, as appropriate, receive instruction in the safe use of durable medical equipment and medical supplies. The licensee may contract with an outside entity to be responsible for ensuring that durable equipment is properly maintained and repaired.

### Section 19a-495-6m Hospice inpatient Facility Physical Plant

- (a) All hospice inpatient facilities shall be of sound construction. Equipment and furnishings shall be maintained in good condition, properly functioning and repaired or replaced when necessary. Requirements shall include:
  - (1) New construction and renovation of hospice inpatient facility buildings and systems shall meet the requirements of the Connecticut State Fire Code, National Fire Protection Association Standards, Health Care Facilities, No. 99; Connecticut State Building Code, applicable local codes and ordinances and the 2010 edition of the Facility Guidelines Institute (FGI)/ American Institute of Architects (AIA) Guidelines for Design and Construction of Health Care Facilities.
  - (2) An operations and preventative maintenance program shall be established and implemented on an ongoing basis to maintain the hospice inpatient facility, systems, equipment and grounds in a clean, sanitary, safe and operational condition.

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- (3) A program shall be established and maintained to provide for the safety and well-being of the hospice inpatient facility occupants and shall provide for the testing, servicing and maintenance of all life safety, emergency and bio-medical equipment in accordance with applicable state laws and regulations and manufacturer recommendations.
- (4) Records of all inspections, testing, maintenance and repairs shall be maintained for Department review.
- (b) Plans and specifications for new construction and rehabilitation, alteration, addition, or modification of an existing structure shall be approved by the Department on the basis of compliance with the Regulations of Connecticut State Agencies after the approval of such plans and specifications by local building inspectors and fire marshals, and prior to the start of construction.
- (c) All floors within the hospice inpatient facility, other than the main entrance floor shall be accessible by elevator. The cars of elevators shall have inside dimensions that shall accommodate a patient bed and attendants.
- (d) All hospice inpatient facilities licensed for more than one hundred and twenty beds shall be connected to a public water supply and sanitary sewer systems.
- (e) Water temperatures shall meet the following requirements to ensure patient safety:
  - (1) In patient areas, hot water temperatures shall not be less than one hundred degrees Fahrenheit and shall not exceed one hundred ten degrees Fahrenheit;
  - (2) Thermostatic or pressure balanced mixing valves are required at each site or fixture used for immersion or showering of patients; and
  - (3) Thermometers or skin sensory methods shall be used to verify the appropriateness of the water temperature prior to each use.
- (f) An emergency source of electricity shall be provided to protect the health and safety of patients in the event the normal electrical supply is interrupted. The source of the emergency electrical service shall be an emergency generator, which shall be located on the premises and shall be reserved exclusively for supplying the emergency electrical system.
  - (1) When fuel to the hospice inpatient facility is not piped from a utility distribution system, fuel shall be stored on site sufficient to provide seventy-two hours of continuous service.
  - (2) The emergency source shall have the capacity for:
    - (A) Delivering eighty percent of normal power;
    - (B) Lighting all means of egress;
    - (C) Equipment to maintain detection, alarm, and extinguishing systems;
    - (D) Life support systems; and
    - (E) Routine patient care.
- (g) Patient areas shall be designed and equipped for the comfort and privacy of each patient and family that includes:
  - (1) Physical space for private patient and family visiting;
  - (2) Accommodations for family members, including children, if they wish to remain with the patient overnight;
  - (3) Family privacy after a patient's death; and
  - (4) A home like environment to the extent possible.

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- (h) Patient rooms shall have a maximum capacity of one patient per room and be located within one hundred and thirty feet of a nursing station.
- (i) Patient bathing facilities shall include:
  - (1) One shower stall or bathtub for every fifteen beds not individually served;
  - (2) A toilet and sink directly accessible to the bathing area; and
  - (3) Bathing and shower rooms shall be of sufficient size to accommodate one patient and one attendant and shall not have curbs.
- (j) Service area requirements shall include but not be limited to:
  - (1) Hand washing facilities conveniently located next to each nurses' station and drug distribution station;
  - (2) A janitor's closet that contains a floor receptacle or service sink, and locked storage space for housekeeping equipment and supplies;
  - (3) A family and patient common area with not less than two hundred twenty-five square feet for every thirty beds;
  - (4) A common dining area with fifteen square feet per patient to accommodate the total patient capacity of the facility that may be combined with the recreation area;
  - (5) A single recreation area of thirty-five square feet per patient and provisions for storage;
  - (6) A comfortable space for spiritual purposes, which shall be appropriately equipped and furnished;
  - (7) For those patients who do not have a private room, a separate room shall be made available for the viewing of a deceased patient's body until released to the responsible agent;
  - (8) A dietary service area of adequate size that includes, but is not limited to:
    - (A) A breakdown and receiving area, storage space for a three day food supply including cold storage;
    - (B) Food preparation facilities with a lavatory;
    - (C) Meal service facilities;
    - (D) Dishwashing space in a room or alcove separate from food preparation and serving areas with commercial-type dishwashing equipment and space for receiving, scraping, sorting, and stacking soiled tableware;
    - (E) Pot washing facilities;
    - (F) Storage areas for supplies and equipment;
    - (G) Waste storage facilities in a separate room easily accessible to the outside for direct pickup or disposal;
    - (H) An icemaker-dispenser unit;
    - (I) A janitor's closet that contains a floor receptacle or service sink; and
    - (J) Locked storage space for housekeeping equipment and supplies.
- (k) An entrance at grade level, sheltered from the weather, and able to accommodate wheelchairs.
- (l) Access to the hospice inpatient facility shall be physically and operationally distinct from other patient care facilities that share the facility space. Visitors shall be prohibited from passing through the hospice inpatient facility space to access another area of the building.

## Connecticut Department of Public Health

### Hospice Inpatient Facilities

- (m) There shall be a laundry service. The licensee may contract for these services. If laundry services are provided on site, they shall comply with the following requirements:
  - (1) A laundry processing room with commercial-type equipment;
  - (2) A soiled linen receiving, holding and sorting room with hand washing facilities;
  - (3) Storage for laundry supplies;
  - (4) Deep sink for soaking clothes;
  - (5) Clean linen storage, holding room and ironing area;
  - (6) Janitor's closet containing a floor receptacle or service sink, and locked storage space for housekeeping equipment and supplies;
  - (7) Off-site processing requires a soiled linen holding room with hand washing facilities, and a clean linen receiving, holding, inspection and storage room; and
  - (8) Each hospice inpatient facility shall have a domestic type washer and dryer located in a separate room for patients' personal use.
- (n) Provisions shall be made by the licensee to ensure the following are maintained at all times:
  - (1) Adequate and comfortable lighting levels in all areas;
  - (2) Limitation of sounds at comfortable levels;
  - (3) Comfortable temperature levels for the patients in all parts of patient occupied areas with a centralized heating system to maintain not less than seventy degrees Fahrenheit during the coldest periods;
  - (4) Adequate ventilation through windows or by mechanical means;
  - (5) Corridors equipped with firmly secured handrails on each side; and
  - (6) Heat relief to patients when the outdoor temperature exceeds eighty degrees Fahrenheit and air conditioning is not available.